CPT® Code: 56820  Colposcopy of the vulva;

Services included in global service when performed:
(Do not report separately):
Included pre-procedure services:
➢ Proper positioning, prepping, and draping of patient
➢ Catheterization or catheter insertion

Included procedure services:
➢ Insertion of speculum
➢ Application of enhancing medium
➢ Injection of local anesthesia
➢ Colposcopy of vulva

Typically included postoperative services:
(See Introduction, Manual Format section, page 14)

Additional included procedures:
➢ None

Non-Medicare Patients: Examples of services excluded from global service when performed:
(Report separately):
➢ Destruction of vaginal lesions (57061-57065)
➢ Vaginal colposcopy (57420-57421)
➢ Cervical colposcopy (57452-57461)
➢ Conization (57520)
➢ Endometrial biopsy (58100)
➢ Dilatation and curettage (58120)
➢ Significant and separately identifiable Evaluation and Management Services. Use modifier 25.

Medicare Patients: Code 56820 is bundled into (or is considered an included component of) these services:
Code 56820 may be reported with these services when appropriate and with a modifier.
➢ Anogenital exam in childhood (99170)

Code 56820 cannot be reported with these services under any circumstances.
➢ Biopsy of vulva (56605, 56821)
➢ Destruction of vulvar lesions (56501-56515)
➢ Incision and drainage of abscess (56405)
➢ Lysis of labial adhesions (56441)
➢ Plastic repair (56800-56810)
➢ Procedures on Bartholin’s glands (56420-56440, 56740)
➢ Procedures on hymen (56442, 56700)
➢ Vulvectomy (56620-56640)

Additional comments:
➢ Code for the most comprehensive service. If colposcopy and biopsy of vulva is performed, report 56821 instead of this code.
➢ This is a Medicare 0 global day procedure. Follow-up care, other than hospital visit(s) to assess patient status, is not included and should be coded separately.

Relative Value:
Work 1.50  Facility 2.47  Non-facility 3.43  Medicare Global Period: 0 days

Assistant at Surgery: Almost never required. Not payable by Medicare.
Co-Surgeon: Not payable by Medicare.
Note that Medicare will not reimburse for an individual to serve as both a primary and assistant surgeon during the same operative session.
**CPT® Code: 59409**  
Vaginal delivery only (with or without episiotomy and/or forceps);

**SERVICES INCLUDED IN GLOBAL SERVICE WHEN PERFORMED (DO NOT REPORT SEPARATELY):**

- **Included antepartum services:**
  - Not included

- **Included intrapartum services:**
  - Admission to L&D, update of history & physical, or any E/M service on the calendar day prior to delivery and/or calendar day of delivery
  - Management of uncomplicated labor including fetal monitoring
  - Preparation of the perineum with antiseptic solution
  - Vaginal delivery with or without forceps or vacuum extraction
  - Delivery of the placenta, any method
  - Episiotomy and repair/suturing of lacerations
  - Injection of local anesthesia
  - Placement of internal fetal and/or uterine monitors
  - Catheterization or catheter insertion
  - Administration of intravenous oxytocin
  - Simple removal of cerclage (not under anesthesia)
  - Exploration of uterus
  - Placement of a hemostatic pack or agent

**NON-MEDICARE PATIENTS: EXAMPLES OF SERVICES EXCLUDED FROM GLOBAL SERVICE WHEN PERFORMED (REPORT SEPARATELY):**

- **Excluded antepartum services:**
  - External cephalic version (59412)
  - Insertion of cervical dilator by physician prior to day of delivery (59200)

- **Excluded intrapartum services:**
  - Administration of regional anesthesia (62322-62323, 62326-64430, 64430-64435)
  - Fetal scalp blood sampling (59090)

- **Excluded postpartum services:**
  - Tubal ligation (58605)
  - Uncomplicated inpatient hospital postpartum visits

**MEDICARE PATIENTS: SERVICES BUNDLED INTO CODE 59409:**

- Code 59409 may be reported with these services when appropriate and with a modifier.
  - Cesarean delivery (59620-59622)
  - Global obstetric package (59618)
  - Vaginal delivery (59410, 59612-59614)

- Code 59409 cannot be reported with these services under any circumstances.
  - None

**ADDITIONAL COMMENTS:**

- Repair of third or fourth degree lacerations at the time of delivery may be reported in one of the following ways: By using a CPT Integumentary section code (eg, 12041-12047 or 13131-13133) or by adding modifier 22 to the delivery code reported.

- If inpatient and outpatient postpartum care is also performed, report 59410 instead of this code.

- If inpatient postpartum care is also performed without outpatient postpartum care, report the appropriate subsequent inpatient Evaluation and Management code.

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**Relative Value:**

- Work: 14.37
- Facility: 23.537
- Non-facility: 23.53

**Medicare Global Period:** Does not apply

**Assistant at Surgery:**

- Almost never required. May be payable by Medicare if medical necessity established with documentation.

**Co-Surgeon:**

- Not payable by Medicare.

Note that Medicare will not reimburse for an individual to serve as both a primary and assistant surgeon during the same operative session.

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